TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-0841-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…each date of service has 2 notes to support the number of units/hours billed for that day. One note is the '97799-Chronic Pain Management Program-Daily Progress Note'. The number of units/hours billed on this particular note is located and circled at the top right hand corner. There are 4 group topics on each Daily Progress Note (Occupational/Vocational, Pain Management, Stress Management, and Family). The second note is the 'Combined Chiropractic Service & Rehabilitation Daily Progress & Therapy Notes'. The number of units/hours is also circled in the upper right hand corner of the note."

Amount in Dispute: $1600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the patient was seen for other services and/or with a different provider on the dates in question, the provider could not have provided 8 hours of services as claimed."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18-19, 2015	Chronic Pain Management	$1600.00	$1600.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.210 sets out medical documentation requirements.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the reimbursement amount for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

Texas Labor Code §413.031(c) states that "In resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules." In addition, a medical fee dispute is defined by 28 Texas Administrative Code §133.305(a)(4) as

> …A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes)…

1. The insurance carrier denied disputed services with claim adjustment reason codes CAC-16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION," and 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED…"

   28 Texas Administrative Code §133.210(c)(3) lists the documentation requirements for return to work rehabilitation programs as:

   > …a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates…

   Review of the submitted information finds that documentation supports the services billed. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Billing and reimbursement for the disputed services is subject to 28 Texas Administrative Code §134.204(h), which states, in relevant part:

   (1) Accreditation by the CARF is recommended, but not required.
   (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.
   (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR…
   (5) The following shall be applied for billing and reimbursement of Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.
(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

Submitted documentation does not support that the disputed services were part of a CARF accredited program. Therefore, the services will be calculated at 80 percent of the maximum allowable reimbursement (MAR), in accordance with 28 Texas Administrative Code §134.204(h)(1)(B).

For date of service June 18, 2015, the requestor is seeking $800.00 for CPT code 97799 with modifier "CP." According to submitted CMS Form 1500, 8 units/hours were billed. Total MAR for 8 hours at $125.00 per hour is $1000.00. 80 percent of MAR is $800.00.

For date of service June 19, 2015, the requestor is seeking $800.00 for CPT code 97799 with modifier "CP." According to submitted CMS Form 1500, 8 units/hours were billed. Total MAR for 8 hours at $125.00 per hour is $1000.00. 80 percent of MAR is $800.00.

3. The total reimbursement amount is $1600.00. The insurance company paid $0.00. Reimbursement of $1600.00 is recommended.

Conclusion

While not all information submitted was discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1600.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1600.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 17, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.